BLS INSECT STING ALLERGY ACTION PLAN

PLACE STUDENT'S PICTURE HERE

RIGHT CLICK ON THIS BOX
CHOOSE "REPLACE IMAGE"
AND REPLACE
WITH ONE FROM YOUR FILES

Name: _____

D.O.B.: ____ /____ /_____ **Allergy to:** _____

Asthma: Yes ____ (higher risk for a sever reaction. No_____

(THIS SECTION TO BE DEDERMINTED BY PHYSICIAN AUTHORIZING TREATMENT)

• **If a bee sting has occurred, but no symptoms**	□ Epinephrine □ Antihistamine
• **Site of sting:** swelling, redness, itching	□ Epinephrine □ Antihistamine
• **Skin**: itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine □ Antihistamine
• **Stomach**: nausea, abdominal cramps, vomiting, diarrhea	□ Epinephrine □ Antihistamine
• **Throat** Tightening of throat, hoarseness, hacking cough	□ Epinephrine □ Antihistamine
• **Lung** Shortness of breath, repetitive coughing, wheezing	□ Epinephrine □ Antihistamine
• **Heart** Thready pulse, low blood pressure, fainting, pale, blueness	□ Epinephrine □ Antihistamine
• **Mouth** If a bee sting has occurred, but no symptoms	□ Epinephrine □ Antihistamine
• **Reaction is progressing (several of the above areas are affected)**	□ Epinephrine □ Antihistamine

The severity of symptoms can quickly change

MEDICATIONS

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator): _____

Prescriber Name/Title: _____ phone: _____

PRESCRIBER SIGNATURE: _____ DATE: _____

SELF-CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION

Prescriber's authorization for self-carry/self-administration of emergency medication:

PRESCRIBER SIGNATURE: _____ DATE: _____

School RN approval for self-carry/self-administration of emergency medication:

RN signature: _____Date: _____

I agree to the above plan, and agree that school health personnel and my child's physician or staff may discuss this plan if there are questions.

Parent/Guardian Signature _____Date_____

Emergency Contact: _____ Mobile Phone: _____

Emergency Contact: _____ Mobile Phone: _____

This form MUST be signed by a licensed health care provider